

TITLE 760 DEPARTMENT OF INSURANCE

Final Rule
LSA Document #98-265(F)

Digest

Adds 760 IAC 1-63 to establish the format for and elements of the health maintenance organization comparison sheet required under IC 27-13-40-1, as added by P.L. 69-1998. Effective January 1, 2000.

760 IAC 1-63

SECTION 1. 760 IAC 1-63 IS ADDED TO READ AS FOLLOWS:

Rule 63. Health Maintenance Organization Comparison Sheets

760 IAC 1-63-1	Authority
Authority:	P.L. 69-1998 §19
Affected:	IC 27-13-40-1

Sec. 1. (a) Beginning January 1, 2000, each health maintenance organization shall complete and maintain a health maintenance organization comparison sheet for each policy or contract that covers or is marketed to an Indiana resident or the resident's employer.

(b) Each health maintenance organization shall modify its health maintenance organization comparison sheet whenever necessary to accurately reflect information about the health maintenance organization.

(c) The format for and elements of the health maintenance organization comparison sheet are set forth in section 2 of this rule. Health maintenance organizations shall report on Part C of the comparison sheet the same information reported to the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS) measures. Information reported shall be for Indiana only. A description of the HEDIS measures shall be displayed as a footnote to each quality measure reported on Part C of the comparison sheet.

(d) A health maintenance organization shall make available upon request to any person to whom a health maintenance organization comparison sheet has or will be delivered all information reported by the health maintenance organization to the NCQA for its HEDIS measures. (*Department of Insurance; 760 IAC 1-63-1*)

760 IAC 1-63-2 HMO comparison sheet
Authority: P.L. 69-1998 §19
Affected: IC 27-13-40-1; IC 27-13-40-2

Sec. 2. The format for and elements of the health maintenance organization comparison sheet are as follows:

HMO NAME: _____

NAME OF PROVIDER NETWORK: _____

Information current as of: [date]

THE FOLLOWING INFORMATION IS A SUMMARY ONLY. PLEASE REVIEW YOUR CERTIFICATE OF COVERAGE FOR A COMPLETE DESCRIPTION OF BENEFITS, LIMITATIONS, AND EXCLUSIONS.

DESCRIPTION OF THE PLAN: [Provide a brief description of the process an enrollee must follow to access care. Explain the role of the primary care physician and restrictions regarding out-of-network benefits and coverage, if applicable.]

PART A: BENEFIT INFORMATION

Benefit	Description	Copayment or Other Charge	Additional Information
PHYSICIAN SERVICES (Indicate differences among primary care physician, specialists, and other where appropriate)			
Office visits			
Routine physicals			
Well baby and child care, including immunizations			
Mammograms			
Maternity (physician and hospital services):			
Surgery			
Other			

OUTPATIENT HOSPITAL SERVICES			
Surgery and related charges			
Physician services			
Emergency care: in area (___ mile radius) out of area (___ mile radius)			
Other			
INPATIENT HOSPITAL SERVICES			
Room and board (indicate any limitations regarding choice of hospital)			
Physician services			
Rehabilitative services (including speech, physical, and occupational therapy)			
Other			
PRESCRIPTION DRUGS			
Formulary brand			
Formulary non-brand			
Nonformulary brand			
Nonformulary non-brand (generic)			
Diabetic supplies			
LABORATORY AND X-RAY (diagnostic and routine)			
SKILLED NURSING FACILITY [insert description of what constitutes a “skilled nursing facility”]			
HOME HEALTH SERVICES			

DURABLE MEDICAL EQUIP- MENT			
PROSTHETICS			
FAMILY PLANNING			
Voluntary sterilization: Male: Female:			
Contraceptive drugs and devices			
INFERTILITY DIAGNOSTIC TESTING			
FERTILITY COVERAGE			
MENTAL HEALTH			
Outpatient			
Inpatient			
SUBSTANCE ABUSE and CHEMICAL DEPENDENCY			
Outpatient			
Inpatient			
THERAPY			
Physical			
Speech			
Occupational			
VISION			
Eye exams			
Glasses or contacts			
Corrective surgery			

HEARING			
Testing			
Hearing aids			
DENTAL			
Preventative			
Orthodontia			
Emergency			
EXCLUSIONS			

PART B: SERVICE AREA

General description of service area:	
Indicate metropolitan areas served:	
Indicate non-metropolitan areas served:	

PART C: QUALITY MEASURES

Additional quality measures, including measures of effectiveness of care and access/availability of care, are available by calling [insert phone number] or writing [insert address].

Quality Measures	[Reporting HMO]
Percentage of primary care physicians who are board certified	
Provider turnover rate	
Disenrollment	
Years in business/total membership (Indiana and national)	
Satisfaction with the experience of care	
Accreditations achieved	

PART D: GRIEVANCE INFORMATION

A Grievance Procedures Report, which contains information about the number, type, and resolution of grievances filed with the HMO during the previous calendar year, is available upon request by calling [insert phone number] or writing [insert address]. (*Department of Insurance; 760 IAC 1-63-2*)

TITLE 760 INDIANA DEPARTMENT OF INSURANCE
LSA DOCUMENT #98-265

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HEARING HELD: May 5, 1999, 311 West Washington Street, Suite 300, Indianapolis,
 IN

IN ACCORDANCE WITH THE AGENCY'S STATUTORY PROVISIONS AND I.C. 4-22-2,
THE ABOVE RULE TEXT WAS ADOPTED BY THE COMMISSIONER IN A FINAL
VERSION OF THE RULE WHICH CONTAINED CHANGES FROM THE PROPOSED
RULE PUBLISHED IN THE INDIANA REGISTER. SAID CHANGES ARE A LOGICAL
OUTGROWTH OF THE PROPOSED RULE AND SUPPORTED BY WRITTEN COMMENT
SUBMITTED TO THE COMMISSIONER.

APPROVED:

Sally McCarty
Commissioner
Date: _____

APPROVED:

Jeffrey A. Modisett
Attorney General of Indiana
Date: _____

APPROVED:

Frank L. O'Bannon
Governor of Indiana
Date: _____

APPROVED:

Sue Anne Gilroy
Secretary of State
Date: _____